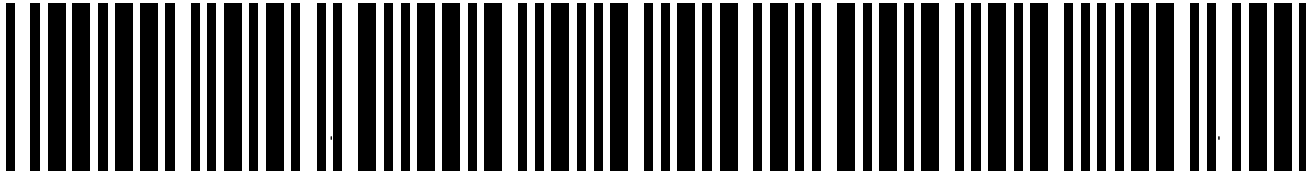


STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☒ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☒

More than 15 Companion Cases ☐

03/26/2020  
Date:(MM/DD/YYYY)

SSN: --

☐ Specific Injury

ADJ12031731  
Case Number 1

☒ Cumulative Injury

06/25/2018  
(Start Date: MM/DD/YYYY)

02/15/2019  
(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 330 HAND

Body Part 3: 340 FINGERS

Body Part 2: 320 WRIST

Body Part 4: 315 ARM

Other Body Parts: 700 MULTIPLE

**Please check unit to be filed on ( check only one box )**

☒ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ SAU ☐ INT ☐ RSU

**Companion Cases**

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 3

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 4

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

+

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 5

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

+

☐ Specific Injury

Case Number 6

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 7

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 8

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



☐ Specific Injury

Case Number 9

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 10

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 11

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



☐ Specific Injury

Case Number 12

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 13

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

☐ Specific Injury

Case Number 14

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



☐ Specific Injury

Case Number 15

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



☐ Specific Injury

Case Number 16

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_

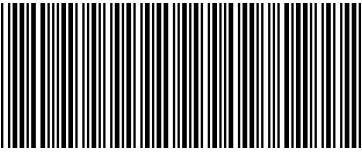
Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_





STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
DECLARATION OF READINESS  
TO PROCEED TO EXPEDITED HEARING (TRIAL)  
[Labor Code section 5502(b) ]

T

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

ADJ12031731  
Case No.

Applicant

JONATHAN  
First Name MI

SHOCKLEY  
Last Name

VS

Employer Information

CARDIONET LLC  
Employer Name (Please leave blank spaces between numbers, names or words)

1000 CEDAR HOLLOW ROAD  
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

MALVERN PA 19355  
City State Zip Code

The Declarant requests that this case be set for expedited hearing and decision on the following issues:

- ☐ Entitlement to medical treatment per Labor Code § 4600, except issues determined pursuant to Labor Code §§ 4610 and 4610.5.
- ☒ Entitlement to temporary disability, or disagreement on amount of temporary disability.
- ☐ Whether there is a properly established MPN in which the employee may obtain treatment. (If requested, this will be the only issue heard at the hearing.) See Labor Code §§ 4603.2(a)(3); 5502(b)(B).
- ☐ Entitlement to compensation is in dispute because of a disagreement between employers and/or carriers.

Declarant states under penalty of perjury that he or she has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed above:

APPLICANT NOT MMI AND ON MOD PER PTP JAMASBI SINCE 10.21.19 INITIAL EVAL AND 1.23.20 QME STOLLER REPORT. NO OFFER MADE. DEF EMAILED EDD 2.27.20, IN RELEVANT PART MR. SHOCKLEY HAS BEEN PLACED BACK ON TEMPORARY DISABILITY. PLEASE STOP PAYMENTS AND LET US KNOW THE LAST DAY OF BENEFITS SO WE CAN AVOID A DISRUPTION IN PAYMENTS. DEF NOW DISPUTES TD. CONVERSATIONS WITH NO RESOLUTION. TD PRIOR TO 10.21.19 RESERVED. WCAB INTERVENTION REQUESTED.

T

Declarant states under penalty of perjury that there is a bona fide dispute; that he/she is presently ready to proceed to hearing; that his/her discovery is complete on said issues.

Declarant's Signature Zechariah K. K. K.

FARBER OAKLAND  
Name of declarant or name of the law firm of the declarant (Print or Type)

333 HEGENBERGER ROAD SUITE 504 OAKLAND CA 94621  
Address (Please leave blank spaces between numbers, names or words)

510.444.2512 Date 03/26/2020  
Phone Number MM/DD/YYYY



UAN: Farber Oakland  
ERN: 7912453  
Ruben Amezcuita  
(510) 444 – 2512 x 130  
Ruben.amezcuita@farberandco.com  
Shockley, Jonathan v. Cardionet LLC; ADJ12031731

**PROOF OF SERVICE BY MAIL**

I, the undersigned, am employed in the County of Alameda; I am over 18 years of age, and I am not a party to the within action; my business address is: Farber & Company Attorneys, P.C., 333 Hegenberger Road Suite 504, Oakland, CA. On March 26, 2020 I served the within:

**Declaration of Readiness, EH**

on the parties listed below in said action by placing a true and correct copy thereof in a sealed envelope with the required postage therein, fully prepaid, for collection and mailing on the date and at the place shown below following ordinary business practices. I am readily familiar with this business' practice for collecting and processing correspondence for mailing. On the same day that this correspondence was placed for collection and mailing, it was deposited in the ordinary course of business in a sealed envelope with postage fully prepaid and deposited in the United States mail at Oakland, CA, addressed as follows:

Workers' Compensation Appeals Board  
1515 Clay Street, 6th Floor  
Oakland, CA 94612

Jonathan Shockley  
1000 Sutter Street - Room 123  
San Francisco, CA 94109

Chubb Group Los Angeles  
P.O. Box 42065  
Phoenix, AZ 85080

Colantoni Collins San Francisco  
201 Spear Street, Suite 1100  
San Francisco, CA 94105

Cardionet LLC  
1000 Cedar Hollow Road  
Malvern, PA 19355

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on March 26, 2020 at Oakland, CA.

  
\_\_\_\_\_  
Maria Gaytan

**State of California, Division of Workers' Compensation**  
**REQUEST FOR AUTHORIZATION**  
**DWC Form RFA**

**Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.**

- ☒ **New Request** ☐ **Resubmission – Change in Material Facts**  
☐ **Expedited Review:** Check box if employee faces an imminent and serious threat to his or her health  
☐ Check box if request is a written confirmation of a prior oral request.

**Employee Information**

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

**Requesting Physician Information**

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

**Claims Administrator Information**

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:


**Requested Treatment (see instructions for guidance, attached additional pages if necessary)**

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other soft tissue disorders related to use, overuse and pressure, left forearm Other soft tissue disorders related to use, overuse and pressure, right forearm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right upper arm	M70.832, M70.831, M70.822, M70.821, Z79.899	12 sessions of Acupuncture for the Bilateral Shoulders, Bilateral Elbows, Bilateral Hands and Bilateral Wrists	97813, 97814, 97026, 97124	
		6 sessions of Massage Therapy for the Bilateral Shoulders, Bilateral Elbows, Bilateral Wrists and Bilateral Hands	97124	

Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

 Requesting Physician Signature:		Date: <b>10/29/2019 at 01:03 PM(PT)</b>
<b>Claims Administrator/Utilization Review Organization (URO) Response</b>		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

**CC:****UR Department (if applicable):**213-612-5785**Applicant Attorney (if applicable):**Zachary Kwellner, Esq. 866-819-6169**Nurse Case Manager (if applicable):**



**Pain & Rehabilitative**  
**CONSULTANTS MEDICAL GROUP**

**BABAK J JAMASBI, MD, FACPM**

Board Certified Pain Medicine& Anesthesiology, QME

**BRENDAN P MORLEY, MD, FACPM**

Board Certified Pain Medicine& Anesthesiology, QME

**TIMOTHY S LO, MD, MPH**

Board Certified in Neurology, Pain Medicine, Medical Acupuncture, QME, Electrodiagnostic Medicine

**ARZHANG ZERESHKI, MD**

Board Certified in Pain Medicine, Physical Medicine & Rehabilitation, QME

**NEIL KAMDAR, MD**

Board Certified Pain Medicine& Anesthesiology

**JOHN ALCHEMY, MD, DABFP, QME**

Board Certified in Family Medicine

**CALLUM EASTWOOD, PSY.D.**

Senior Director of Behavioral Medicine

**MARIEL BARCEBAL, PSY.D.**

Clinical Psychologist

**GABRIELLE REIMAN, PSY.D.**

Clinical Psychologist

**KATHERINE KIMSEY, MFT, EdD**

Clinical Psychologist

**MARK PHILLIPS, PA**

Physician Assistant

**SUSIE PAIK, PA-C**

Physician Assistant

**DONNY CHO, PA-C**

Physician Assistant

**JULIA FELLOWS, PA-C**

Physician Assistant

**THRISHA KASHINATH, PA-C**

Physician Assistant

**ROBERT ESTIS, PA**

Physician Assistant

**JESSICA AIKIN, PA-C**

Physician Assistant

**MARIA CUTLER, DC**

Chiropractor

Reply To:

EMERYVILLE OFFICE

1335 STANFORD AVENUE

EMERYVILLE, CA 94608

(P) 510-647-5101 -- (F) 510-647-5105

Other Offices:

CASTRO VALLEY

SAN FRANCISCO

WALNUT CREEK

ROHNERT PARK

MANTECA

**INITIAL EVALUATION**

**RE:** Shockley, Jonathan

**DOB:** 09/27/1978

**DOI:** 02/15/19

**EMPLOYER:** Biotelemetry, Inc.

**INSURANCE:** Chubb

**CL#:** 040519008736

**DATE OF SERVICE:** 10/21/19

**INTRODUCTION**

I have evaluated Mr. Shockley in my Emeryville office on 10/21/19 in consultation. After reviewing his records I have accepted him as a patient. The patient has also selected me to be his primary treating physician.

**HISTORY OF PRESENT ILLNESS**

The patient is a 41-year-old right-handed man who was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left. His left developed pain problems. He initially had pain around the wrist area. The pain has gradually traveled up the arm towards the neck. He also has occasional hand pain.

**CURRENT COMPLAINTS**

The pain is constant at low level, exacerbated by hand activity. The pain wakes him up at night. When he does not do anything, his hand does not hurt. The pain increases with activity, especially computer work, cellphone use, and writing. Inactivity, Advil, deep massage makes the pain better.

He denies any numbness and tingling.

**ACTIVITIES OF DAILY LIVING**

He is uncomfortable looking after himself performing self-care activities and is slow and careful in doing so. He can lift and carry heavy objects, but gets extra discomfort in doing so. He is able to walk the same distance as before his injury. He can do heavy activity for at least 2 minutes. He can climb 1 flight of stairs without difficulty. He can sit for 30 minutes to 1 hour without difficulty. He can sit for 2 hours without difficulty. He can stand or walk for 2 hours without difficulty. He has some difficulty reaching and grasping things at eye level. He

**INITIAL EVALUATION**

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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has some difficulty reaching and grasping things overhead. He has some difficulty with pushing or pulling activities. He has a lot of difficulty gripping, grasping, holding and manipulating objects using his hands. He has a lot of difficulty with repetitive motions such as typing on a computer. He has a lot of difficulty with forceful activities using his hands. He can kneel, bend or squat without difficulty. His sleep is moderately disturbed 2 to 3 hours nightly since his injury. His sexual activity is a little less frequent because of his injury. At this moment, his pain is moderate. His pain is moderate most of the time. His pain interferes with his ability to travel and engage in social activities some of the time. His pain interferes with his ability to engage in recreational activities most of the time. His pain interferes with his ability to concentrate and think some of the time. He has moderate depression or anxiety from his injury and discomfort most of the time.

**REVIEW OF SYMPTOMS**

Patient states they are currently experiencing:

Patient states they are **not** currently experiencing:

Pain in neck  
Anxiety

Chills  
Fever  
Night sweats  
Severe fatigue  
Dizziness  
Headaches  
Wears Contacts  
Wears glasses  
Blurry vision  
Double vision  
Lumps in neck  
Difficulty breathing  
Cough  
Coughing up blood  
Wheezing  
Difficulty breathing lying flat  
Fainting  
Abnormal heartbeat  
Chest pain  
Constipation  
Heartburn  
Nausea

Abdominal pain  
Black tarry stools  
Throwing up blood  
Urinary incontinence  
Blood in urine  
Difficulty urinating  
Painful urination  
Itching of skin  
Rash  
Yellowing of skin  
Balance problems  
Poor concentration  
Memory loss  
Numbness  
Seizures  
Tremors  
Weakness  
Excessive bleeding  
Blood clots  
Depression  
Hallucinations  
Suicidal thoughts

**PAST MEDICAL HISTORY**

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.

INITIAL EVALUATION

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

**PAST SURGICAL HISTORY**

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

**FAMILY HISTORY**

Patient does not have a family history of drug addiction.

Patient has a family history of chronic pain.

**PSYCH/SOCIAL HISTORY**

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

**PSYCHOLOGICAL TESTING**

The patient was administered psychological testing (PHQ-SADS). This test is a screening test for anxiety, depression and the impact of somatic symptoms. The purpose of the test is to screen patients for psychological aspect of chronic pain to help the clinician incorporate additional

## INITIAL EVALUATION

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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adjunctive treatment. Provision of adjunctive psychotherapy can have a significant impact on efficacy of medical treatment.

## SOMATIC (PHQ-15)

The patient has a somatic (PHQ-15) score of 5, which indicates he is mildly bothered by somatic issues.

## ANXIETY (GAD-7)

The patient's anxiety (GAD-7) score is 5, which indicates he is experiencing mild anxiety.

## PANIC ATTACKS

He does not experience panic attacks.

## DEPRESSION (PHQ-9)

The patient's depression (PHQ-9) score is 1, which indicates he is experiencing minimal depression.

## FUNCTIONAL DIFFICULTIES

The patient's functional difficulties are 4, which indicate his functions are extremely difficult.

The purpose of the psychological testing is to determine if there are any psychological factors that will affect the patient's progress with medical treatment. The testing is also used to determine whether the patient needs a formal psychological evaluation or any psychological treatment as an adjunct to the medical treatment.

Based on my clinical assessment of the patient and the psychological testing, I believe that this patient would be a candidate for an initial evaluation at a CARF-certified functional restoration program once the patient has exhausted medical and surgical treatment.

**OPIOID RISK TOOL**

<b>Family History of Substance Abuse</b>	√	<i>Score for Female</i>	<i>Score for Male</i>
Alcohol		1	3
Illegal Drugs		2	3
Prescription Drugs		4	4

<b>Personal History of Substance Abuse</b>	√	<i>Score for Female</i>	<i>Score for Male</i>
Alcohol		3	3
Illegal Drugs		4	4
Prescription Drugs		5	5

## INITIAL EVALUATION

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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Age (Mark if 16-45)	√	Score for Female	Score for Male
	√	1	1

History of Preadolescent Sexual Abuse	√	Score for Female	Score for Male
		3	0

Psychological Disease	√	Score for Female	Score for Male
Attention Deficit Disorder		2	2
Obsessive Compulsive Disorder		2	2
Bipolar Schizophrenia		2	2
Depression		1	1

Total	Low Risk 0-3	Moderate Risk 4-7	High Risk >=8
1	1		

**OCCUPATIONAL HISTORY**

The patient was working for Biotelemetry, Inc. at the time of the injury.

He is not currently working.

The patient last worked on 02/15/19.

He had worked at Biotelemetry, Inc. for 8 months prior to injury.

He had worked for the following companies prior to this injury:

1. SF Ballet
2. Tulsa Ballet
3. Boston Ballet
4. Biotelemetry, Inc./Lifewatch

His job duties at the time of injury were processing and editing EKGs from cardiac devices, answering calls regarding same

He does have prior work injuries:

1. 1997 left ankle sprain, different employer, resolved
2. 1998, all toes, different employer, resolved
3. 2000, right big toe bone spur, different employer, resolved
4. 2001 right chronic Achilles tendinitis, different employer, settled

He does not have prior motor vehicle accidents.

He does not have prior non-motor vehicle accidents.



**INITIAL EVALUATION**

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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**MILITARY SERVICE**

The patient has not served in the military.

**MEDICATIONS**

1. Aspirin
2. Advil

**ALLERGIES**

No known drug allergies

**PHYSICAL EXAMINATION**

The patient is a well-developed, well-nourished man who did not appear to be in any acute distress.

Height: 6' 0"

Weight: 165 LBS.

**Spine:** There was discomfort with lateral tilt of the cervical spine. Loading of the cervical facets were not tender.

Range of motion of the cervical spine:

<b>Range of Motion of the Cervical spine</b>	<b>Normal/Reduced by %</b>
Flexion	NL
Extension	NL
Lateral tilt to the Right	15%
Lateral tilt to the Left	25%
Rotation to the Right	NL
Rotation to the Left	NL

**Musculoskeletal:** There were no impingement signs in the shoulders. There was no lateral or medial epicondylar pain. Finkelstein's were negative bilaterally. Palpation of the volar aspect of the wrists were tender bilaterally.

Range of motion of the shoulder:

	<b>Right (Normal/Reduced by %)</b>	<b>Left (Normal/Reduced by %)</b>
Flexion	NL	NL
Extension	NL	NL
Abduction	NL	NL
Adduction	NL	NL
External rotation	NL	NL
Internal rotation	NL	NL

## INITIAL EVALUATION

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

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Range of motion of the elbow:

	Right (Normal/Reduced by %)	Left (Normal/Reduced by %)
Flexion	NL	NL
Extension	NL	NL

Range of motion of the wrist:

	Right (Normal/Reduced by %)	Left (Normal/Reduced by %)
Flexion	NL	NL
Extension	NL	NL
Ulnar Deviation	NL	NL
Radial Deviation	NL	NL

**Neurologic:** The patient is alert and oriented x3. He walks with a normal gait.

Reflexes:

	Right	Left
Biceps	2/4	2/4
Triceps	2/4	2/4
Brachioradialis	2/4	2+

Sensory examination of the upper extremities:

Upper Extremity Sensory Examination	Right	Left
C4	NL	NL
C5	NL	NL
C6	NL	NL
C7	NL	NL
C8	NL	NL
T1	NL	NL
T2	NL	NL

☐ D- Diminished to a pinprick☐ NL- Normal

Motor examination of the shoulders:

Motor examination of the shoulders	Right	Left
Flexion	NL	NL
Abduction	NL	NL
Adduction	NL	NL
Internal Rotation	NL	NL
External Rotation	NL	NL
Extension	NL	NL

**INITIAL EVALUATION**

RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

Page 8 of 9

Motor examination of the elbows:

<b>Motor examination of the elbows</b>	<b>Right</b>	<b>Left</b>
Flexion	NL	NL
Extension	NL	NL

Grip: Grip strength was normal and symmetrical.

**SPECIAL TESTING**

I have conducted a urine tox screen, which was negative for any illicit drugs or any prescribed scheduled drugs. I am not planning to prescribe him any controlled substances and further confirmation of this test is not indicated.

**DIAGNOSIS**

1. Cumulative trauma injury to both upper extremities.

**DISCUSSION**

This gentleman has had cumulative trauma injury to both upper extremities. The pain initially started in the right wrist. The pain gradually started traveling up the arm up to the level of the shoulder. The left hand became painful around the same area/wrist. This was as a compensation for the right. The pain on the left also radiates up to the shoulder.

Upon examination, he had normal range of motion in all the joints of his upper extremities. There was no evidence of a neurological deficit. I believe this gentleman does have cumulative trauma injury, which is brought on by activity. He has not worked now for a while and his symptoms are better during the examination.

I recommend 12 sessions of acupuncture and 12 sessions of soft tissue mobilization/massage therapy.

If he does not respond to conservative measures, an evaluation at a CARF-certified functional restoration program would be indicated.

I will see him back in 4 weeks in follow up.

**Work Restrictions:**

Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

**WORK STATUS**

The patient is not permanent and stationary.

INITIAL EVALUATION

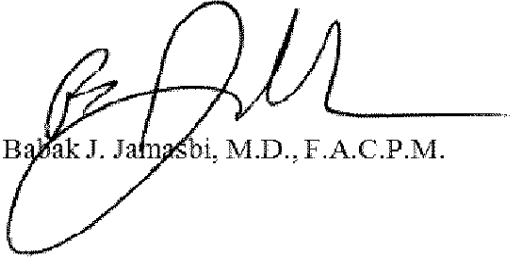
RE: Shockley, Jonathan

DATE OF SERVICE: 10/21/19

Page 9 of 9

*"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to be the best of my knowledge and beliefs, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."*

*"I further declare that I have not violated labor code section 139.3 and have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation."*

A handwritten signature in black ink, appearing to read 'B. Jamasbi', with a large, stylized loop at the end.

Babak J. Jamasbi, M.D., F.A.C.P.M.

CC:

Mario Castro, Claims Adjuster

Fax #: 800-664-1765

Zachary Kweiler, Attorney-At-Law

Fax #: 866-819-6169

**State of California, Division of Workers' Compensation**  
**REQUEST FOR AUTHORIZATION**  
**DWC Form RFA**

**Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.**

- ☒ **New Request** ☐ **Resubmission – Change in Material Facts**  
☐ **Expedited Review:** Check box if employee faces an imminent and serious threat to his or her health  
☐ Check box if request is a written confirmation of a prior oral request.

**Employee Information**

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

**Requesting Physician Information**

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

**Claims Administrator Information**

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:

**Requested Treatment (see instructions for guidance; attached additional pages if necessary)**

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other long term (current) drug therapy	M70.832, M70.831, M70.822, M70.821, Z79.899	6 sessions of Acupuncture for the Bilateral Hands	97813, 97814, 97026, 97124	

**Treatment must be paid under the California OMFS**

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

Date: **12/02/2019 at 10:16 AM(PT)**

Requesting Physician Signature:



**Claims Administrator/Utilization Review Organization (URO) Response**

- ☐ **Approved** ☐ **Denied or Modified** (See separate decision letter) ☐ **Delay** (See separate notification of delay)  
☐ **Requested treatment has been previously denied** ☐ **Liability for treatment is disputed** (See separate letter)

Authorization Number (if assigned):

Date:

Authorized Agent Name:

Signature:

Phone:

Fax Number:

E-mail Address:

Comments:

DWC Form RFA (Effective 2/2014)

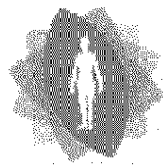
Page 1

**CC:**

**UR Department (if applicable):**213-612-5785

**Applicant Attorney (if applicable):**Zachary Kweiler, Esq. 866-819-6169

**Nurse Case Manager (if applicable):**



## **Pain & Rehabilitative**

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### **CONSULTANTS MEDICAL GROUP**

Babak Jamasbi, MD | Brendan Morley, MD  
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

### **Visit Note - SF (San Francisco) Appointment**

**Provider:**

**Supervising:** Babak J. Jamasbi, M.D.

**Performing:** Jessica Aikin, PA-C

**Encounter Date:** Nov 22, 2019

**Patient:** Shockley, Jonathan (PT00023609)

**Sex:** Male

**DOB:** Sep 27, 1978    **Age:** 41 Year 1 Month 3 Week

**Address:** 1000 Sutter St Room 123, San Francisco CA 94109    **Pref. Phone(H):**  
415-312-4029

**Primary Dr.:** Babak Jamasbi, M.D.

**Referred By:** Babak Jamasbi, M.D.

**Injury Date:** 02/15/2019

**Employer:** Biotelemetry, Inc

**Case Insurance:** Chubb Son of Federal Ins Company

**Claim No.:** 040519008736

**VISIT TYPE:**

**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley came to our office today for a follow-up visit.

**SUBJECTIVE COMPLAINTS:**

Patient is here to follow up on pain in his bilateral hands.

He continues to report bilateral hand pain, right greater than left. Occasionally pain radiates up his arms towards his neck. Pain is worse with repetitive use of his upper extremities, excessive

typing or computer work. Pain is better with conservative treatment.

He reports having a pain flair with the use of massage therapy, this dramatically increased his pain.

He also has been going to acupuncture treatment. This does help with his pain.

With regard to medication, he does take Advil as needed for pain.

**ROS:**

**Constitutional:**

Patient denies chills, fever, night sweats, or severe fatigue.

**Head:**

Patient denies dizziness or headaches.

**Eyes:**

Patient denies wearing corrective lenses, blurry vision, or double vision.

**Neck:**

Patient complains of pain but denies lumps in his neck.

**Respiratory:**

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

**Cardiovascular:**

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

**Gastrointestinal:**

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

**Genitourinary:**

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

**Skin:**

Patient denies itching of skin, rash, or yellowing of skin.

**Neurologic:**

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

**Hematologic:**

Patient denies excessive bleeding or blood clots.

**Psychiatric:**

Patient complains of anxiety but denies depression, hallucinations and suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

**OBJECTIVE FINDINGS:**

**Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed.

**Orientation:**

Patient is alert and oriented x3.

**Mood and Affect:**



Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

**Gait and Station:**

No abnormalities observed.

**Musculoskeletal - Strength:**

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

**Skin:**

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

**Current Medications:**

1. Advil (OTC)

2. Aspirin Ec 81 Mg Tablet (OTC)

**FORMAL REQUEST FOR AUTHORIZATION:**

6 sessions of acupuncture 97813, 97814, 97026, 97124 Hand Bilateral Hands.

**DIAGNOSIS:**

Z79.899 Other long term (current) drug therapy

**PRESCRIPTION:**

**1 Voltaren 1% Gel** SIG: Apply to affected area daily QTY: 1.00.

**TREATMENT PLAN:**

Assessment:

during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

Plan:

- He will continue with acupuncture treatment, he has approximately 7 appointments remaining. Before acupuncture treatment his pain is a an 4-6/10, this will decrease down to approximately down to a 2-3/10, this allows him to use his hands more. We will request for 6 additional sessions so he can continue this.
- Ok to discontinue massage therapy, TENS dramatically increased his pain.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated.
- Voltaren gel prescribed today.
- He is scheduled for QME on Jan 23, 2020.

**Follow up in 4 weeks.**

**WORK STATUS:**

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

**TIME SPENT:**

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

\*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

**CC:**

Kweller, Esq., Zachary : 12/02/2019

Castro, Mario : 12/02/2019

UR, Chubb : 12/02/2019

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 11/26/2019

**State of California, Division of Workers' Compensation**  
**REQUEST FOR AUTHORIZATION**  
**DWC Form RFA**

**Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.**

- ☒ **New Request** ☐ **Resubmission – Change in Material Facts**  
☐ **Expedited Review:** Check box if employee faces an imminent and serious threat to his or her health  
☐ Check box if request is a written confirmation of a prior oral request.

**Employee Information**

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

**Requesting Physician Information**

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

**Claims Administrator Information**

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:

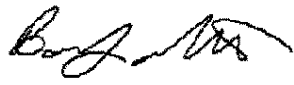
**Requested Treatment (see instructions for guidance; attached additional pages if necessary)**

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

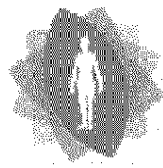
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other soft tissue disorders related to use, overuse and pressure, left forearm Other soft tissue disorders related to use, overuse and pressure, right forearm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right upper arm	M70.832, M70.831, M70.822, M70.821, Z79.899	<b>EMG of the Bilateral Upper Extremities to be performed at Pain &amp; Rehabilitative Consultants Medical Group</b>	<b>95913; 95886</b>	

Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

		Date: <b>01/22/2020 at 07:58 AM(PT)</b>
Requesting Physician Signature:		
<b>Claims Administrator/Utilization Review Organization (URO) Response</b>		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

**CC:****UR Department (if applicable):**213-612-5785**Applicant Attorney (if applicable):**Zachary Kweiler, Esq. 866-819-6169**Nurse Case Manager (if applicable):**



## **Pain & Rehabilitative**

---

### **CONSULTANTS MEDICAL GROUP**

Babak Jamasbi, MD | Brendan Morley, MD  
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

### **Visit Note - SF (San Francisco) Appointment**

**Provider:**

**Supervising:** Babak J. Jamasbi, M.D.

**Performing:** Julia Fellows, PA-C

**Encounter Date:** Jan 15, 2020

**Patient:** Shockley, Jonathan (PT00023609)

**Sex:** Male

**DOB:** Sep 27, 1978    **Age:** 41 Year 3 Month 2 Week

**Address:** 1000 Sutter St Room 123, San Francisco CA 94109    **Pref. Phone(H):**  
415-312-4029

**Primary Dr.:** Babak Jamasbi, M.D.

**Referred By:** Babak Jamasbi, M.D.

**Injury Date:** 02/15/2019

**Employer:** Biotelemetry, Inc

**Case Insurance:** Chubb Son of Federal Ins Company

**Claim No.:** 040519008736

**VISIT TYPE:**

**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley came to our office today for a follow-up visit.

**SUBJECTIVE COMPLAINTS:**

Patient is here to follow up on pain in his bilateral hands.

He presents for an early follow up today due to a flare up of pain. He reports increased pain,

R>L, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity.

He reports improvement with acupuncture treatment, he has recently been approved for 6 additional sessions. With regard to massage therapy, he reports that this did not really help as the practitioner was only able to focus on his hands, while it's really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands.

**ROS:**

**Constitutional:**

Patient denies chills, fever, night sweats, or severe fatigue.

**Head:**

Patient denies dizziness or headaches.

**Eyes:**

Patient denies wearing corrective lenses, blurry vision, or double vision.

**Neck:**

Patient complains of pain but denies lumps in his neck.

**Respiratory:**

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

**Cardiovascular:**

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

**Gastrointestinal:**

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

**Genitourinary:**

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

**Skin:**

Patient denies itching of skin, rash, or yellowing of skin.

**Neurologic:**

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

**Hematologic:**

Patient denies excessive bleeding or blood clots.

**Psychiatric:**

Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

**Medical History:**

**PAST MEDICAL HISTORY**

1. Bronchitis 2 years ago.
2. Eczema.

3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

#### **PAST SURGICAL HISTORY**

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

#### **Social History:**

#### **PSYCH/SOCIAL HISTORY**

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

#### **OBJECTIVE FINDINGS:**

##### **Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed.

##### **Orientation:**

Patient is alert and oriented x3.

##### **Mood and Affect:**

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

##### **Gait and Station:**

No abnormalities observed.

##### **Musculoskeletal - Strength:**

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:



Arm Abduction 5/5  
Forearm Flexion 5/5  
Forearm Extension 5/5  
Wrist Extension 5/5  
Thumb Apposition 5/5  
Digit Abduction 5/5.

**Skin:**

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.  
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.  
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.  
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

**Current Medications:**

1. Voltaren 1% Gel Apply to affected area daily
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

**FORMAL REQUEST FOR AUTHORIZATION:**

EMG of the Bilateral Upper Extremities to be performed at Pain & Rehabilitative Consultants Medical Group 95913; 95886.

**DIAGNOSIS:**

- M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm  
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm  
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm  
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

**TREATMENT PLAN:**

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

He presents due to an acute increase in his upper extremity symptoms.

On exam he has full ROM of the bilateral shoulders with some discomfort. His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbow. He has never had an EMG of the upper extremities to assess for ulnar or median neuropathy before. At this time, given that his symptoms have persisted for greater than 6 months and responded only minimally to conservative treatment, we will request for an EMG at this time. Pending the results, we may consider a referral to a specialist.

He has been approved for 6 more acupuncture sessions and will scheduled these.

He is scheduled for QME on Jan 23, 2020. We will review this report when available.

**Follow up in 4-6 weeks.**

**WORK STATUS:**

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

**TIME SPENT:**

To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.

\*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

#### **JUSTIFICATION:**

**EMGs - Hand, Wrist, Forearm:** The following has been recommended by the MTUS/ACOEM Guidelines regarding EMGs

Electrodiagnostic Studies to Evaluate Non-specific Hand, Wrist, or Forearm Pain in Patients with Paresthesias or Other Neurological Symptoms

Recommended. Electrodiagnostic studies are recommended to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Moderate

Indications: Persistent tingling and pain, particularly symptoms characteristic of radiculopathies and entrapment neuropathies. Providers are cautioned that the prevalence rate of abnormal electrodiagnostic studies in asymptomatic populations are high (see CTS section above) and interpretations of abnormal findings should be cautious.

Frequency/Dose/Duration: Should generally be performed at least 3 weeks after symptom onset.

Rationale: There is 1 low-quality study evaluating electrodiagnostic studies for non-specific pain. However, electrodiagnostic studies may assist in diagnosing and treating the condition and thus are recommended.

Evidence: There is 1 low-quality study in Appendix 2.(1128)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Electrodiagnostic, studies, Nerve conduction, study, NCS, Electromyography, EMG, Non-specific, hand, wrist, forearm, paint controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random\*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 31 articles in PubMed, 10870 in Scopus, 298 in CINAHL, 183 from Google Scholar, and 7 in Cochrane Library. We considered for inclusion 1 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 11358 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

**CC:**

Kweller, Esq., Zachary : 01/22/2020

Castro, Mario : 01/22/2020

UR, Chubb : 01/22/2020

This visit note has been electronically signed off by Jamasbi, Babak J., M.D. on 01/21/2020

**State of California, Division of Workers' Compensation**  
**REQUEST FOR AUTHORIZATION**  
**DWC Form RFA**

**Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.**

- ☒ **New Request** ☐ **Resubmission – Change in Material Facts**  
☐ **Expedited Review:** Check box if employee faces an imminent and serious threat to his or her health  
☐ Check box if request is a written confirmation of a prior oral request.

**Employee Information**

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

**Requesting Physician Information**

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

**Claims Administrator Information**

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:


**Requested Treatment (see instructions for guidance, attached additional pages if necessary)**

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other soft tissue disorders related to use, overuse and pressure, left forearm Other soft tissue disorders related to use, overuse and pressure, right forearm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right upper arm	M70.832, M70.831, M70.822, M70.821, Z79.899	6 sessions of Massage Therapy for the bilateral upper extremities	97124	

Treatment must be paid under the California OMFS

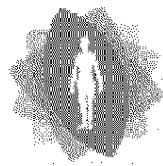
Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0

		Date: <b>02/03/2020 at 07:54 AM(PT)</b>
Requesting Physician Signature:		
<b>Claims Administrator/Utilization Review Organization (URO) Response</b>		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (Effective 2/2014)

Page 1

**CC:****UR Department (if applicable):**213-612-5785**Applicant Attorney (if applicable):**Zachary Kweiler, Esq. 866-819-6169**Nurse Case Manager (if applicable):**



## **Pain & Rehabilitative**

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### **CONSULTANTS MEDICAL GROUP**

Babak Jamasbi, MD | Brendan Morley, MD  
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

### **Visit Note - SF (San Francisco) Appointment**

**Provider:**

**Supervising:** Babak J. Jamasbi, M.D.

**Performing:** Jessica Aikin, PA-C

**Encounter Date:** Jan 10, 2020

**Patient:** Shockley, Jonathan (PT00023609)

**Sex:** Male

**DOB:** Sep 27, 1978    **Age:** 41 Year 3 Month 1 Week

**Address:** 1000 Sutter St Room 123, San Francisco CA 94109    **Pref. Phone(H):**  
415-312-4029

**Primary Dr.:** Babak Jamasbi, M.D.

**Referred By:** Babak Jamasbi, M.D.

**Injury Date:** 02/15/2019

**Employer:** Biotelemetry, Inc

**Case Insurance:** Chubb Son of Federal Ins Company

**Claim No.:** 040519008736

**VISIT TYPE:**

**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley came to our office today for a follow-up visit.

**SUBJECTIVE COMPLAINTS:**

Patient is here to follow up on pain in his bilateral hands.

Patient denies acute changes to his pain complaints. He continues to report bilateral hand and arm pain, right greater than left. Occasionally pain radiates up from his hands into his bilateral



forearms and up towards his neck. Pain is worse with repetitive use of his upper extremities, typing, or computer work. Pain is better with conservative treatment.

He reports improvement with acupuncture treatment, he has recently been approved for 6 additional sessions. With regard to massage therapy, he reports that this did not really help as the practitioner was only able to focus on his hands, while it's really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands.

With regard to medication, he reports improvement with the use of Voltaren gel. He denies side effects with the use of this medication. He requests for a refill today.

**ROS:**

**Constitutional:**

Patient denies chills, fever, night sweats, or severe fatigue.

**Head:**

Patient denies dizziness or headaches.

**Eyes:**

Patient denies wearing corrective lenses, blurry vision, or double vision.

**Neck:**

Patient complains of pain but denies lumps in his neck.

**Respiratory:**

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

**Cardiovascular:**

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

**Gastrointestinal:**

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

**Genitourinary:**

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

**Skin:**

Patient denies itching of skin, rash, or yellowing of skin.

**Neurologic:**

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

**Hematologic:**

Patient denies excessive bleeding or blood clots.

**Psychiatric:**

Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

**Medical History:**

**PAST MEDICAL HISTORY**

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

#### **PAST SURGICAL HISTORY**

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

#### **Social History:**

#### **PSYCH/SOCIAL HISTORY**

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

#### **OBJECTIVE FINDINGS:**

##### **Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed.

##### **Orientation:**

Patient is alert and oriented x3.

##### **Mood and Affect:**

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

##### **Gait and Station:**

No abnormalities observed.

##### **Musculoskeletal - Strength:**

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

**Skin:**

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

**Current Medications:**

1. Voltaren 1% Gel Apply to affected area daily

2. Advil (OTC)

3. Aspirin Ec 81 Mg Tablet (OTC)

**FORMAL REQUEST FOR AUTHORIZATION:**

6 sessions of Massage Therapy (97124)- for the bilateral upper extremities.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

**DIAGNOSIS:**

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

**PRESCRIPTION:**

**1 Voltaren 1% Gel** SIG: Apply to affected area daily QTY: 1.00.

**TREATMENT PLAN:**

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

He is off work at this time.

Plan:

- He has been approved for 6 additional sessions of acupuncture treatment, we will monitor his response to this.
- We will request for 6 sessions of massage therapy for his bilateral arms, rather than just his bilateral hands.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated. He continues to be off work.
- Voltaren gel refilled today.
- He is scheduled for QME on Jan 23, 2020. We will review this report when available.

**Follow up in 4-6 weeks.**

**WORK STATUS:**

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

**TIME SPENT:**

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. \*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

**JUSTIFICATION:**

**Voltaren Gel:** The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects

of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

**CC:**

Kweller, Esq., Zachary : 02/03/2020

Castro, Mario : 02/03/2020

UR, Chubb : 02/03/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 01/31/2020

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue  
Emeryville, CA 94608

Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley Date 02

1000 Sutter St Room 123 San Francisco, CA 94109

Address

6 sessions of Massage Therapy for the  
bilateral upper extremities

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm  
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm  
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm  
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

Refill



☐ Mark Phillips, P.A.  
DEA#: MP0998558 / LIC#: PA17702

☒ Babak Jamasbi, M.D.  
DEA#: B12563345 / LIC#: G70042

☐ Timothy Lo, M.D.  
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.  
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshti, M.D.  
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.  
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.  
DEA#: BP4661369 / LIC#: 55085

☐ Susie Park, P.A.-C  
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Q  
DEA#: M  
Julia M. F  
DEA#: M  
Robert J. I  
DEA#: M  
Jessica A  
DEA#: M  
Shohreh S  
DEA#: M

**State of California, Division of Workers' Compensation**  
**REQUEST FOR AUTHORIZATION**  
**DWC Form RFA**

**Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.**

- ☒ **New Request** ☐ **Resubmission – Change in Material Facts**  
☐ **Expedited Review:** Check box if employee faces an imminent and serious threat to his or her health  
☐ Check box if request is a written confirmation of a prior oral request.

**Employee Information**

Name (Last, First, Middle): **Shockley, Jonathan**

Date of Injury (MM/DD/YYYY): **02/15/2019**

Date of Birth (MM/DD/YYYY): **09/27/1978**

Claim Number: **040519008736**

Employer: **Biotelemetry, Inc**

**Requesting Physician Information**

Name: **Dr. Jamasbi, Babak J,**

Practice Name: **PRCMG**

Contact Name: **Bembem G.**

Address: **1335 Stanford Ave**

City: **Emeryville**

State: **CA**

Zip Code: **94608**

Phone: **510-647-5101 x133**

Fax Number: **510-647-5105 or 510-540-6965**

Specialty: **Pain Management**

NPI Number: **1376637199**

E-mail Address:

**Claims Administrator Information**

Company Name: **Chubb Son of Federal Ins Company**

Contact Name: **Castro, Mario**

Address: **P.O. Box 42065**

City: **Phoenix**

State: **AZ**

Zip Code: **85080**

Phone: **213-612-5378**

Fax Number: **800-664-1765**

E-mail Address:

**Requested Treatment (see instructions for guidance, attached additional pages if necessary)**

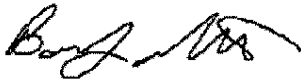
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Other soft tissue disorders related to use, overuse and pressure, left forearm Other soft tissue disorders related to use, overuse and pressure, right forearm Other soft tissue disorders related to use, overuse and pressure, left upper arm Other soft tissue disorders related to use, overuse and pressure, right upper arm	M70.832, M70.831, M70.822, M70.821, Z79.899	12 sessions of Acupuncture for the Bilateral hands, wrists and forearms	97813, 97814, 97026, 97124	

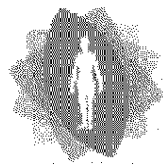
Treatment must be paid under the California OMFS

Peer to Peer calls: Mon-Friday:3:30pm -5pm PT. Please call (510) 647-5101 x0



		Date: <b>03/04/2020 at 07:33 AM(PT)</b>
Requesting Physician Signature:		
<b>Claims Administrator/Utilization Review Organization (URO) Response</b>		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

**CC:****UR Department (if applicable):**213-612-5785**Applicant Attorney (if applicable):**Zachary Kwellner, Esq. 866-819-6169**Nurse Case Manager (if applicable):**



## **Pain & Rehabilitative**

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### **CONSULTANTS MEDICAL GROUP**

Babak Jamasbi, MD | Brendan Morley, MD  
Timothy Lo, MD | Arzhang Zereshti, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

### **Visit Note - SF (San Francisco) Appointment**

**Provider:**

**Supervising:** Babak J. Jamasbi, M.D.

**Performing:** Julia Fellows, PA-C

**Encounter Date:** Feb 26, 2020

**Patient:** Shockley, Jonathan (PT00023609)

**Sex:** Male

**DOB:** Sep 27, 1978 Age: 41 Year

**Race:** Unreported/Refused to Report

**Address:** 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H):  
415-312-4029

**Primary Dr.:** Babak Jamasbi, M.D.

**Referred By:** Babak Jamasbi, M.D.

**Injury Date:** 02/15/2019

**Employer:** Biotelemetry, Inc

**Case Insurance:** Chubb Son of Federal Ins Company

**Claim No.:** 040519008736

**VISIT TYPE:**

**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:**

Mr. Shockley came to our office today for a follow-up visit.

**SUBJECTIVE COMPLAINTS:**

Patient is here to follow up on pain in his bilateral hands.

At his last visit, he presented early due to a flare up of pain. Today he still reports increased pain, R>L, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity.

He reports improvement with acupuncture treatment, and he has completed all of his approved sessions. He would like to continue this if possible. He started massage therapy and it did cause some increased pain. He will try to be more vocal with the therapist.

The patient states that he underwent a MRI and upper extremity EMG through his QME 3 weeks ago. We do not have this report for review.

**ROS:**

**Constitutional:**

Patient denies chills, fever, night sweats, or severe fatigue.

**Head:**

Patient denies dizziness or headaches.

**Eyes:**

Patient denies wearing corrective lenses, blurry vision, or double vision.

**Neck:**

Patient complains of pain but denies lumps in his neck.

**Respiratory:**

Patient denies difficulty breathing, cough, coughing up blood, or wheezing.

**Cardiovascular:**

Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.

**Gastrointestinal:**

Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.

**Genitourinary:**

Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.

**Skin:**

Patient denies itching of skin, rash, or yellowing of skin.

**Neurologic:**

Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.

**Hematologic:**

Patient denies excessive bleeding or blood clots.

**Psychiatric:**

Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

**Medical History:**

**PAST MEDICAL HISTORY**

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

#### **PAST SURGICAL HISTORY**

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

#### **Social History:**

#### **PSYCH/SOCIAL HISTORY**

The patient does not smoke cigarettes.

The patient does not drink alcoholic beverages.

The patient does not use illicit drugs.

The patient is not married.

The patient has a significant other.

The patient has no children.

Patient does not have a family history of childhood abuse.

Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

#### **OBJECTIVE FINDINGS:**

##### **Constitutional - General Appearance:**

Patient is near ideal body weight and is well groomed.

##### **Orientation:**

Patient is alert and oriented x3.

##### **Mood and Affect:**

Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

##### **Gait and Station:**

No abnormalities observed.

##### **Musculoskeletal - Strength:**

RUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

LUE:

Arm Abduction 5/5

Forearm Flexion 5/5

Forearm Extension 5/5

Wrist Extension 5/5

Thumb Apposition 5/5

Digit Abduction 5/5.

**Skin:**

No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.

No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

**Current Medications:**

1. Voltaren 1% Gel Apply to affected area daily

2. Advil (OTC)

3. Aspirin Ec 81 Mg Tablet (OTC)

**FORMAL REQUEST FOR AUTHORIZATION:**

12 sessions of acupuncture 97813, 97814, 97026, 97124 Bilateral hands, wrists and forearms.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

**DIAGNOSIS:**

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

**PRESCRIPTION:**

**1 Voltaren 1% Gel** SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00.

REF: 1 update amount

Changed/Discontinued Medication(s):

Changed: VOLTAREN 1% GEL - update amount

**TREATMENT PLAN:**

**Assessment:**

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

On exam he has full ROM of the bilateral shoulders with some discomfort. His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbow.

We will request for 6 additional sessions of acupuncture today.

He underwent a QME on Jan 23, 2020 and the patient had a MRI and EMG through this QME. We will review this when available.

**Follow up in 4-6 weeks.**

**WORK STATUS:**

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

**TIME SPENT:**

To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(c) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under

fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. \*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

#### **JUSTIFICATION:**

**Acupuncture - Hand, Wrist, Forearm:** The following has been recommended by the MTUS/ACOEM Guidelines regarding Acupuncture

##### **Acupuncture**

Acupuncture has been used to treat CTS and other hand, wrist, and forearm MSDs.(790, 791) There is evidence of its efficacy for treatment of chronic spine disorders, although the evidence suggests traditional acupuncture is not superior to other acupuncture methods (see Chronic Pain and Low Back Disorders Guidelines).

##### **Acupuncture for Acute, Subacute, or Chronic CTS**

Not Recommended. Acupuncture is not recommended for treatment of acute, subacute, or chronic CTS.

Strength of Evidence – Not Recommended, Evidence (C)

Level of Confidence – Low

Rationale: There are quality trials of acupuncture compared with placebo or sham acupuncture and they have failed to show benefit of acupuncture for treatment of CTS.(792) One trial found no differences between acupuncture and oral steroid.(793, 794) Another trial susceptible to contact time bias found minimal differences between acupuncture and nocturnal wrist splinting.(781) Thus, the highest quality evidence suggests acupuncture is ineffective for treatment of CTS and acupuncture is not recommended.

Evidence: There are 4 moderate-quality RCTs incorporated into this analysis.(781, 792-794) There are 3 low-quality RCTs in Appendix 2.(795-797)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and



Cochrane Library without date limits using the following terms: Acupuncture, Acupuncture Therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random,\* randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 40 articles in PubMed, 411 in Scopus, 83 in CINAHL, 46 in Cochrane Library and 0 in other sources. We considered for inclusion 7 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

**Voltaren Gel:** The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to

prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

**CC:**

Kweller, Esq., Zachary : 03/04/2020

Castro, Mario : 03/04/2020

UR, Chubb : 03/04/2020

This visit note has been electronically signed off by Fellows, Julia, PA-C on 03/02/2020

DEA#: MP1537856 / LIC#: PA19005

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January 23, 2020

**PANEL QUALIFIED MEDICAL EVALUATION - ML-102**

**RE:** SHOCKLEY, Jonathan  
**DOB:** 09/27/1978  
**INSURANCE:** Chubb Group Insurance Company  
**CLAIM #:** 7173815490  
**DOI:** 02/15/2019  
**EMPLOYER:** CardioNet

Dear Concerned Parties:

Mr. Jonathan Shockley had an appointment for Remedy Medical Group at 01/23/20 on 490 Post Street, Suite 900, San Francisco, California 94102 from 1 p.m. to 2 p.m. I spent one hour face-to-face with the patient. Rosa Fesili assisted me with record review. A total of forty-five minutes were spent in record review. This will be billed as an ML-102.

**HISTORY OF PRESENT ILLNESS:**

Mr. Shockley is a right-handed EKG technician at CardioNet. His job is comprised of processing approximately thousand EKGs an hour, which involves about seven hours of day of sitting to work on the computer, extensive mouse clicking, and keyboarding. He has a history of hand and wrist pain in 2009 while he was teaching ballet. He saw a hand surgeon, Dr. Markison, who recalls that he has right-sided greater than left-sided tenosynovitis that resolved several weeks after its onset. He started working in June 2018 at CardioNet. He noticed initially that his right hand started hurting and he got a left-handed mouse in October 2018. He had no right hand improvement and then his left hand and forearm started hurting him. He got a pedal, so he could click with his foot in December 2018 and his foot started bothering him.

On 02/15/19, he had extreme pain in both hands and arms and reported it to his boss. He was sent to see Dr. Lang, who is a hand surgeon. The hand surgeon sent him to PT where they did an ultrasound and hot and cold therapy which did not help. He was not offered any injection or further therapies. He was made permanent and stationary and Dr. Jamasbi later saw him and did acupuncture, massage, and during the course of treatment of Dr. Jamasbi, he received some TENS therapy which he states caused a flare-up of his pain. He has not received TENS since that episode, but he reports that his pain on the right side still goes up into his right shoulder.

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RE: SHOCKLEY, Jonathan

### CURRENT COMPLAINTS:

He reports bilateral arm aching and burning and bilateral neck aching. He states that his bilateral arm pain is constant and moderate in intensity and he has intermittent neck pain that is mild and he has arm numbness and tingling that is intermittent and mild. He also reports moderate loss of sexual functioning.

His neck pain ranges from 2 to 3 out of 10. His arm pain is currently between a 3 and a 4 out of 10. His pain is exacerbated by lifting, hand activity, writing, cleaning, and dressing. It is better with rest, acupuncture, and massage. Ibuprofen and diclofenac are also helpful in alleviating his pain. He has no problems with sitting, standing, or walking tolerance. Treatment for his current problem; He went to Golden Gate Hand Therapy for nine weeks twenty-five weeks ago. He had a 5% improvement. He had acupuncture with Andreas Schwerte for eight weeks, which improved his pain by 25%. He denies any problems with gait or loss of bladder or bowel control. The sports or activities he is unable to perform include ballet, chess teaching, house repairs, lifting heavy objects, cleaning, and/or cooking massage, sexual activities, and card playing.

His sleep is affected. It is hard to fall asleep when he has a flare of his pain. He gets six to seven hours of sleep a night. He has difficulty both falling asleep and staying asleep.

He states that a lot of activities are affected because he is unable to use his hands or his fingers.

His mood is affected. He has increased anxiety despair, which he is managing with medication.

His gastrointestinal system is not affected.

His functional limitations include not being able to write, use a computer or cell phone, difficulty with cooking, cleaning, lifting heavy objects, playing sports, house repairs and projects, teaching ballet or chess, firmly shaking hands. He cannot lift any more than 5 pounds.

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RE: SHOCKLEY, Jonathan

**MEDICAL HISTORY:**

1. Anxiety.

**SURGICAL HISTORY:**

1. Adenoidectomy.
2. LASIK surgery.
3. Sympathectomy.
4. Big toe bone spur removal.
5. Achilles tendon debridement.

**SOCIAL HISTORY:**

He is single. He does not consume any alcohol. He does not use any tobacco products.

**FAMILY HISTORY:**

Rheumatoid arthritis.

**REVIEW OF SYSTEMS:**

Fourteen-point review of systems is positive for the aforementioned problems, otherwise, negative.

**OCCUPATIONAL HISTORY:**

He worked as an EKG tech initially at BioTelemetry LifeWatch, started in June 2018. He was with this employer for a year. He was in the occupation for a year.

His previous employer was Pacific Chess Academy. He was with them for two years.

In the course of a normal workday, he states he was sitting for seven and a half hours. The demands that restrict him from regular duty are continuous computer work with mousing and keyboarding.

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RE: SHOCKLEY, Jonathan

He was satisfied with his job.

**TREATING PROVIDERS:**

1. Dr. Patrick Lang.
2. Dr. Babak Jamasbi.
3. Dr. Robert Markison.

**CURRENT MEDICATIONS:**

1. Advil, taking a total of 1600 mg a day.
2. Voltaren cream.
3. Aspirin 81 mg.

**DRUG ALLERGIES:**

He has no known drug allergies.

**VALIDATED QUESTIONNAIRES:**

1. PHQ-9 is 1/30, indicating no reactive depression.
2. Epworth Sleepiness Scale is 3, indicating no abnormal daytime somnolence.

**QUESTIONS CONCERNING ACTIVITIES OF DAILY LIVING:**

1. Self-care activities are uncomfortable and done slowly.
2. I can lift and carry heavy objects, but I get extra discomfort.
3. There has been no change in his ability to walk after the injury.
4. He states very heavy activity is the most strenuous level of activity he can do for at least two minutes.
5. He has no difficulty climbing a flight of stairs.
6. He can sit without any time limitation.
7. He can stand or walk between one to two hours at a time.
8. He has some difficulty with reaching and grasping for something off of a shelf at chest level.

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RE: SHOCKLEY, Jonathan

9. He has some difficulty reaching and grasping for something off of a shelf overhead.
10. He can push or pull heavy objects.
11. He has a lot of difficulty with griping, grasping, holding, and manipulating objects with his hands.
12. He has a lot of difficulty with repetitive motions such as typing on a computer.
13. He has a lot of difficulty with forceful activities with his arm and hands.
14. He has no difficulty with kneeling, bending, and squatting.
15. His sleep is moderately disturbed because of his injury.
16. There has been a moderate change in his sexual function due to his injury.
17. His pain is moderate at the moment.
18. His pain is moderate most of the time.
19. His pain and injury interfere with his ability to travel some of the time.
20. Most of the time, his pain and injury interfere with his ability to do daily chores.
21. Some or little of the time, his pain and injury interfere with his ability to engage in social activities.
22. A lot or most of the time, his pain and injury interfere with his ability to engage in recreational activities.
23. Some of the time, his pain and injury interfere with his ability to concentrate or think.
24. His pain and injury have caused mild depression or anxiety.
25. He believes that the following statements are true:
  - a. I am afraid that if I exercise, I will hurt myself.
  - b. My body is telling me I have something dangerously wrong.
26. There has been a severe change with his ability to communicate by typing and writing. There has been no change regarding communication by hearing, seeing, or speaking.
27. Regarding his ability to work, I cannot do my usual work and can hardly do any work at all.

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RE: SHOCKLEY, Jonathan

**SPECIFIC WORK AND FUNCTIONAL CAPACITY ACTIVITY ESTIMATE BY THE PATIENT AT PRESENT TIME:**

1. He can do six to eight hours of the following:
  - a. Sitting.
2. He can do four to six hours of the following:
  - a. Walking.
3. He can do two to four hours of the following:
  - a. Bending and twisting at the waist.
  - b. Kneeling.
  - c. Climbing stairs.
  - d. Walking over uneven ground.
  - e. Squatting.
  - f. Climbing ladders.
4. He can do less one to two hours of the following:
  - a. Repetitive neck motions.
  - b. Static neck posturing.
5. He can do less than one of the following:
  - a. Repetitive use of the upper extremity.
  - b. Gripping and grasping with my left hand.
  - c. Pushing and pulling on the left.
  - d. Fine manipulation with my left hand.
  - e. Reaching at shoulder level on the left.
  - f. Reaching above shoulder level on the left.
  - g. Repetitive use of the right upper extremity.
  - h. Gripping and grasping with the right hand.
  - i. Fine manipulation with the right hand.
  - j. Pushing and pulling on the right.
  - k. Reaching at shoulder level on the right.
  - l. Reaching above shoulder level on the right.

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RE: SHOCKLEY, Jonathan

6. He can do zero hours of the following:
  - a. Forceful use of the left upper extremity.
  - b. Forceful use of the right upper extremity.
  - c. Lifting and carrying 5 pounds.

### MEDICAL RECORD REVIEW:

3.1.2019 P. Lang, MD. Hand surgery consultation for bilateral hand, wrist, and forearm pain. Patient is a right handed electrocardiogram technician who reports several month history of worsening bilateral hand, wrist, and forearm pain. Physical exam: Tinel's sign in ulnar nerve at the elbow is negative bilaterally, Finkelstein's test is negative bilaterally, Watson's test negative bilaterally, forearm compartments are soft and nontender. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: recommend occupational hand therapist on a repetitive strain protocol. Optimize computer workstation ergonomic and use dragon software, follow up 6-8 weeks.

3.18.2019, 3.20.2019, 3.25.2019, 3.27.2019, 4.1.2019, 4.3.2019, 4.8.2019, 4.10.2019, 4.15.2019, 4.17.2019, 4.22.2019, 4.24.2019, 5.3.2019, 5.10.2019, 5.15.2019, 5.22.2019, 5.29.2019 A. Ting, OT., C. Wong, OT. Occupational therapy for bilateral hands. Diagnosis: pain in left hand. Pain in the right hand.

4.16.2019 P. Lang, MD. Hand surgery follow up for bilateral upper extremities. Patient reports improvement, used to have pain and bilateral hand, wrist and forearm, symptoms continue to wax and wane relative duplicate or use. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: patient made some adjustments to ergonomic workstation which provides some mild improvement of symptoms, will maintain work restrictions from computer use for the next six weeks, continue to work with occupational therapist call follow-up in six weeks. Work status: no computer youth.

5.28.2019 P. Lang, MD. Hand surgery follow-up for bilateral upper extremities. Patient symptoms remain unchanged. Patient did undergo a formal ergonomic evaluation of the computer workstation. The patient has been off of work for several weeks now and the group is persistent, patient reports he was on the phone and started having right wrist and forearm pain from simply holding the phone. Diagnosis: same. Plan: patient symptoms are classic for

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RE: SHOCKLEY, Jonathan

repetitive strain injury, recommend we designate him permanent stationary pheasant permanent work restriction of no computer use. No follow-up needed.

**PHYSICAL EXAM:**

**General:**

Well-nourished, well-developed gentleman, in no acute distress.

**Cardiac:**

His extremities are warm and well perfused.

**Pulmonary:**

He is breathing comfortably on room air.

**HEENT:**

He has moist mucous membranes. He has tenderness to palpation in his cervical paraspinal muscles. He has 90 degrees of rightward and leftward rotation. He has C-spine flexion of 80 degrees, extension 20 degrees. All extremes of motions of the C-spine cause him to have neck pain. Lateral bending is 10 degrees bilaterally with pain at 10 degrees.

**Musculoskeletal:**

Bilateral 5/5 grip strength, bilateral 5/5 first to second and first to fifth digit grip strength. 5/5 biceps and triceps strength. Shoulder forward flexion is 160 degrees bilaterally with extension 50 degrees bilateral. Shoulder abduction is 120 degrees bilateral and adduction is 20 degrees bilateral.

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RE: SHOCKLEY, Jonathan

Neuro:

He has negative Tinel's sign bilaterally at the carpal tunnel and negative Tinel's bilaterally at the cubital tunnel. He has 1/2 biceps reflexes, 0/2 triceps reflexes, and 0/2 brachioradialis reflexes. Sensation is normal in his upper and lower extremities to light touch.

Psych:

Regular speech, tone, and prosody. Logical thought process. Odd affect.

IMPRESSION:

1. Cervicalgia.
2. Bilateral forearm and hand pain.

DIAGNOSTIC STUDIES:

1. He requires a bilateral upper extremity nerve conduction study/EMG.
2. He requires a cervical spine MRI.

PERMANENT AND STATIONARY STATUS:

He is not permanent and stationary. He needs further diagnostic workup. Once that workup is done and the appropriate treatment is offered, he should then be examined for first permanent and stationary status.

CAUSATION:

100% causation is found to the 02/15/19 cumulative trauma injury.

APPORTIONMENT:

He does have a previous injury in his upper extremities. I would like to see documentation of this to appropriately apportion current injury and its role in his pain.

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RE: SHOCKLEY, Jonathan

**WORK RESTRICTIONS:**

He should lift no more than 5 pounds at the current time.

**FUTURE CARE:**

1. He requires medication for neuropathic pain, topical medications, and medications for myofascial pain.
2. He should continue to see Dr. Jamasbi for treatment.
3. He may require cervical epidural steroid injection.
4. He may require trigger point injections.
5. He requires twenty sessions of acupuncture.
6. He may require twelve sessions of physical therapy every six months for the next four years for flares.
7. He is an ideal candidate for a functional restoration program.

Thank you for allowing me to be your QME. Should you have any questions, please constitute them in a form of request for supplemental and I would be happy to address them.

*"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."*

Sincerely,

Adam J. Stoller, M.D.

0123 27662624

CC: Mario Castro, Claims Adjuster  
James Goines, Defense Attorney  
Zachary Kweiler, Applicant Attorney

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